Reply from the Authors:

To the Editor,

We sincerely thank the authors for their interest in our article. Their recognition of the importance of our work and their willingness to engage in scholarly discussion are highly appreciated. We welcome the opportunity to respond to the comments and critiques raised regarding our manuscript titled "2025 Status Epilepticus in Critically Ill Children."[1]

The authors note that intravenous diazepam was the sole agent recommended as first-line treatment in our article. However, our manuscript clearly delineates first-line treatment strategies for pediatric status epilepticus based on the availability of intravenous access. Specifically, intravenous diazepam, intramuscular midazolam, and rectal diazepam are all cited as appropriate first-line agents. As mentioned by the authors, intravenous lorazepam is not currently available in our country, and thus, was not included in the treatment recommendations.[1]

The suggestion that a national study on pediatric status epilepticus management should have preceded the development of our guideline is a valuable one. While such a study would undoubtedly provide insight into local clinical practices, the primary objective of our guideline was to evaluate the efficacy of therapeutic agents based on the international literature. As we emphasized in our article, the guideline was developed through rigorous review of global evidence, with the understanding that individual institutions may tailor their implementation according to their own resources and settings.

The Status Epilepticus in Critically Ill Children Guideline was developed under the auspices of the neurocritical care working group of the Turkish Society of Pediatric Emergency and Intensive Care Medicine. Prior to drafting the guideline, the working group conducted a comprehensive literature review using predefined keywords to identify relevant meta-analyses, guidelines, and reviews indexed in the PubMed database up to the final editorial review date of the article. Following this, the group convened weekly meetings over a two-year period to develop and refine the recommendations.

All treatment options, including those for first-line therapy, were discussed extensively and decided upon collectively. The sources referenced by the authors were among those reviewed during this process. However, current evidence continues to support the American Epilepsy Society guideline as the most reliable and evidence-based reference on this topic.[2] Notably, neither the American Epilepsy Society guideline nor the 22nd edition of Nelson Textbook of Pediatrics (March 2024) includes intravenous midazolam as a first-line treatment.[3,4] Consequently, we did not provide a dosage recommendation for intravenous midazolam within that context.

It is important to emphasize that our guideline offers recommendations, not mandates. Each healthcare institution retains the autonomy to adapt practices according to local needs and capabilities. Nonetheless, we believe that guidelines should be grounded in high-quality evidence, rather than reflect variable clinical practices. All treatments and medications included in our guideline were evaluated based on both their evidence-based efficacy and their availability in our country. None of the authors have any financial or professional conflicts of interest related to the pharmaceutical companies manufacturing these drugs.

In conclusion, the current version of the guideline represents the outcome of extensive review and deliberation by our working group. We believe it offers a sound framework for clinical practice while remaining adaptable to local conditions. As the number of pediatric emergency and intensive care specialists continues to grow in our country, we anticipate that further contributions-including clinical studies, in addition to guidelines and reviews-will enrich the global literature on pediatric status epilepticus.

Sincerely,

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